STATE OF VERMONT

HUMAN SERVICES BOARD

In re	)	Fair Hearing No. 16,822
	)	
Appeal of	)	

INTRODUCTION

The petitioner appeals the decision by the Department of Aging and Disabilities (DAD) substantiating a report of abuse by the petitioner against a disabled adult.

FINDINGS OF FACT

1. On August 2, 2000 DAD received a report from a community mental health services organization that the petitioner, an employee of that organization, had physically and emotionally abused S, a mentally retarded adult who was a client of that organization, while she was in the petitioner's care. The allegations stemmed primarily from the eyewitness account of another employee of the organization who was with the petitioner caring for S at the time of the alleged incident.

2. The coworker told the DAD investigator and testified at the hearing that on the evening of July 31, 2000 she and the petitioner were providing overnight crisis respite care for S at a day facility owned by the community mental health service.

3. S, who is fifty-four, has a history of aggressive and self-abusive behavior. She is nonverbal, but can understand simple communication and directions and can usually communicate her own needs to her caregivers. She was described as short, stout, and physically quite strong.

4. Prior to the incident in question S had been living for two months with a home provider in a private residence. S had her own room in this home with a bed, but the provider testified that sometimes S chose to sleep on the floor of her room.

5. In July 2000 S's home provider had fallen and broken her wrist, which was in a cast. S would sometimes grab the home provider's wrist when she was agitated in what appeared to be a deliberate attempt to hurt the home provider. On July 31, 2000 the home provider was having difficulty coping with S and asked the agency to provide respite care for S overnight.

6. The petitioner had worked with the agency for 11 years as a respite care provider for disabled adults. She had worked regularly with S since 1996, and at the time in question was providing day care for S several times a week. She had developed a close relationship with S and was highly regarded by her employer and by S's legal guardian and by S's home provider.

7. As a client of the mental health agency S had a written support plan or "protocol" that her caregivers were expected to review and be familiar with. The primary component of the plan centered on S's self-injurious behavior. The plan contained a multi-step process to try to redirect S

when she engaged in that behavior and, if necessary for S's safety, specifically defined physical interventions that would minimize trauma to S. Under no circumstances were S's caregivers to shout or swear at her or to physically coerce her unless her safety was in jeopardy.

8. On the evening of July 31 S was taken from her home and brought to the agency's day care center. The center was only marginally equipped for overnight stays. A futon mattress and blankets were available for sleeping. There were only rudimentary cooking and eating facilities.

9. When S was brought to the center that night a male caseworker and a female substitute respite worker had been called in to care for S. The substitute had worked with S on occasion previously and was aware of S's protocol, but she had had only limited previous experience working with S. The petitioner was scheduled to arrive at 10 p.m. to spell the male caseworker.

10. The petitioner did arrive at the center around 10 p.m., and began making sleeping arrangements for S and the substitute coworker. The coworker testified that the petitioner appeared to be under stress when she arrived and showed little patience with S. The petitioner admitted, and S's home care provider testified that she also knew that the

petitioner had recently been under some personal stress unrelated to her work.

11. There appears to be no dispute that the agency considered S to be "in crisis" that night and that her behavior was especially difficult. The coworker testified that the petitioner yelled and swore at S that night and was physically forceful trying to help S put her nightgown on.

12. The coworker also testified that the petitioner "made" S sleep on the floor while she and the coworker slept on the mattress. There is no evidence, however, that S wanted to sleep anywhere but on the floor that night. It does not appear that any of them got more than a few hours sleep that night.

13. Early the following morning the three of them went in the petitioner's car for coffee and bagels and returned to the center to eat them. When they got back to the center S would not go inside and ran to the side of the building toward a garden hose with a nozzle that she had a history of attempting to use to abuse herself with. S grabbed the hose nozzle and began hitting and scraping herself on the head with it. The coworker testified that the petitioner forcefully took the hose from S and forcibly led her by the wrists into the center where she continued to hold S's arms and yell at her.

14. The coworker stated that S appeared to be upset and "shocked" but calmed down soon thereafter. The coworker stated she did not attempt to intervene because she deferred to the petitioner's experience with S, but later that morning

the coworker told her supervisor of the incidents that had occurred early that morning and the night before.

15. Later that morning, August 1, 2000, the petitioner's supervisor was at the center and observed the petitioner being verbally harsh with S, including an incident where the petitioner threatened to take S's hat from her. The supervisor was concerned because the petitioner appeared to be "spiteful" and "overstressed" in her dealings with S. The petitioner stated that shortly before the supervisor had come into the room S had grabbed her by the hair and she had struggled with S to get her to release her grip.

16. The next day, the "senior leader" at the agency met with the petitioner to discuss the incidents. He testified that the petitioner told him she didn't recall the specifics of the events but admitted she might have sworn at S. She told the leader that she had been having personal difficulties and was seeing a therapist. The agency relieved the petitioner of her duties and reported the incidents to DAD.

17. After its investigation, DAD determined that the incidents constituted statutory abuse of S by the petitioner.

18. Although the petitioner denies the details and severity of most of the allegations, the weight of credible evidence establishes that the incidents in question occurred largely as reported and testified to by the coworker and supervisor who were with the petitioner the evening of July 31 and the morning of August 1, 2000.

19. The evidence does not establish, however, that any of the petitioner's actions toward S placed S's life, health, or

welfare in jeopardy or were likely to result in the impairment of S's health. It also cannot be found that the petitioner ever intended to harm S or acted in reckless disregard of S's health.

20. S's guardian and her home provider both testified in the petitioner's behalf at the hearing. Although neither of them witnessed the incidents in question or would condone what was reported about them, both testified that S was a difficult client and that the petitioner was an excellent caregiver for her.

ORDER

The Department's decision substantiating the report of abuse by the petitioner is reversed.

REASONS

33 V.S.A. § 6902 includes the following:

As used in this chapter:

(1) "Abuse" means"

(A) Any treatment of an elderly or disabled adult which places life, health or welfare in jeopardy or which is likely to result in impairment of health;

(B) Any conduct committed with an intent or reckless disregard that such conduct is likely to cause unnecessary harm, unnecessary pain or unnecessary suffering to a elderly or disabled adult;

(C) Unnecessary confinement or unnecessary restraint of an elderly or disable adult;

. . .

> (5) "Disabled adult" means a person eighteen years of age or older, who has a diagnosed physical or mental impairment.
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> (12) "Substantiated report" means that the commissioner or the commissioner's designee has determined after the investigation that a report is based upon accurate and reliable information that would lead a reasonable person to believe that the elderly or disabled adult has been abused, neglected or exploited.

As noted above, at the time of the incidents in question S's behavior was particularly difficult. She was being particularly aggressive with increased attempts to engage in self-abusive behavior. Unfortunately, the petitioner was also under a lot of stress at that time.

Although it is clear from the evidence that the petitioner violated her employer's protocols for dealing with S's behaviors on the dates in question, it cannot be concluded this amounted to abuse of S as defined in the above statute. There is no evidence that any of the petitioner's actions (other than perhaps some momentary "shock") had any adverse physical or mental effect on S, or were likely to do so, either long or short term.

Although protocols exist for the welfare and safety of individuals like S, it has not been shown that an isolated lapse in such protocols by a caregiver, especially under unusual and stressful circumstances, necessarily results, or is likely to result, in harm to the disabled person. Nor can it be concluded that momentary non-injurious physical restraint and redirection applied to a disabled adult to prevent self-abusive or violent behavior constitutes abuse of

that individual simply because it exceeds the disabled individual's protocols.

Without question, disabled adults are entitled to treatment and care that maximizes their dignity and personal choices; and community mental health agencies must insist that their employees provide such treatment to their clients at all times. Unfortunately, from the petitioner's testimony it appears that over time she found it difficult to avoid the tendency to relate to S in a maternal as opposed to a strictly professional manner. Based on the evidence, however, the worst that can be found is that on the days in question the petitioner treated S much the same way that a stressed and distracted parent might treat an unruly child. While this was an inappropriate and unacceptable professional standard of care, absent any showing of harm to S, or the likelihood of harm, it cannot be concluded that the petitioner's actions on the days in question constituted "abuse" of S within the meaning of the above statute.

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